South Dakota Medical Assistance Authorization Agreement For Direct Deposit of Payment

I hereby authorize the Department of Social Services, Division of Medical Services to initiate direct deposit of my payment into the depository which I have indicated below, and to initiate any debit or credit entries to my account which may be needed to correct any errors that have occurred.

Provider Name: _____

Medical Assistance Provider Number: _____

Financial Institute: _____

Branch: _____

City: _____ State: _____ Zip: _____

Transit ABA No: _____

Account No: _____

Type of Account (Checking or Savings) _____

PLEASE ATTACH A VOIDED CHECK TO ASSURE ACCURATE ACCOUNT INFORMATION.

This agreement is to remain in full force and effect until the Division of Medical Services has received written notification from me of its termination in such time and in such manner as to afford the Division of Medical Services and the depository a reasonable time to act.

Authorized Signature: _____ Date: _____

Contact Person: _____ Telephone #: _____

Please return this form to:

Provider Enrollment
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291